Key messages

- The numbers of patients on hospital waiting lists and the length of time they wait are used extensively as performance indicators
- Increasing the numbers of admissions improves waiting times but not list size
- Targeted funding often fails to achieve its objectives
- Use of waiting list initiatives should be reviewed

validation of the list alone could not justify the expense of these initiatives.

Waiting list initiatives were intended to act as catalysts to encourage other, more definitive, measures that would improve waiting times. The NHS Management Executive considered that the decline in the numbers of people waiting two years and over owed more to waiting lists having a higher priority for existing resources than to targeted additional funding.[11] This study provides further evidence that earmarked funds have often failed to improve waiting lists by increasing the number of admissions.

Waiting list initiatives from central funds have now ceased in line with the government's policy of devolving funding decisions to local health authorities.[12] Purchasing authorities are, however, being asked to achieve progressively more stringent waiting time targets for inpatients and new targets for outpatients.[13] These authorities are inclined to use their reserve funds for waiting list initiatives towards the end of the financial year, to ensure that these targets are met. The allocation of substantial funds which may not be available in the next financial year is deeply unpopular with managers of hospital trusts, who cannot use these funds to make substantive appointments or to develop facilities. Funds released in the middle of winter are particularly difficult for trusts to use effectively because beds are fully occupied with emergency admissions.

Before purchasers divert further resources into waiting list initiatives they should consider, firstly, the evidence on the effectiveness of this approach[14,15] and, secondly, the relative priority of the health need represented by waiting lists for elective surgery.[16,17]

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1 Radical Statistics Health Group. NHS "indicators of success": what do they tell us? *BMJ* 1995;310:1045-50.
2 Department of Health. *Health service charter*. London: HMSO, 1992.
3 Pope C. Cutting queues or cutting corners: waiting lists and the 1990 NHS reforms. *BMJ* 1992;305:577-9.
4 Goldacre MJ, Lee A, Don B. Waiting list statistics I: relation between admissions from the waiting list and length of waiting list. *BMJ* 1987;295: 1105-8.
5 Pope C. Trouble in store: some thoughts on the management of waiting lists. *Sociology of Health and Illness* 1991;13:193-212.
6 Frankel S. The natural history of waiting lists: some wider explanations for an unnecessary problem. *Health Trends* 1989;21:56-8.
7 Parmar JR. A waiting list initiative in general surgery—experience in a large district general hospital. *Ann R Coll Surg Engl* 1993;75 (suppl 1):4-6.
8 Williams M, Frankel S, Nanchahal K, Coast J, Donovan J. *Epidemiologically based needs assessment: total hip replacement surgery*. 2nd ed. London: Department of Health, 1992.
9 Department of Health NHS Executive. *Hospital waiting list statistics: England*. Leeds: NHS Executive, 1987-94.
10 Arnstein PM, Bryson R. The waiting list initiative: a cautionary tale. *Br J Plastic Surg* 1991:44;553-4.
11 Committee of Public Accounts. *Fourth report. Progress on NHS operating theatres and waiting lists in England*. London: HMSO, 1992.
12 NHS Executive. *Waiting time policy*. Leeds: NHS Executive, November, 1994. (EL(94)90.)
13 NHS Executive. *Revised and expanded patient's charter*. Leeds: NHS Executive, 1994.(EL(94)101.)
14 Umeh HN, Reece-Smith H, Faber RG, Galland RB. Impact of a waiting list initiative on a general surgical waiting list. *Ann R Coll Surg Engl* 1994;76 (suppl 1):4-7.
15 Mills RP, Heaton JM. Waiting list initiatives: crisis management or targeting of resources. *J R Soc Med* 1991;84:405-7.
16 Naylor CD, Slaughter PM. A stitch in time: case for assessing the burden of delayed surgery. *Quality in Health Care* 1994;3:221-4.
17 Hemingway H, Jacobson B. Queues for cure? Let's add appropriateness to the equation. *BMJ* 1995;310:818-19.

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Acquired immunodeficiency without HIV infection: epidemiology and clinical outcome in Italy

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Cases of acquired immunodeficiency without HIV infection, but with depletion of CD4 T lymphocytes have been reported since 1989. We estimated the prevalence of this condition in Italy and evaluated its clinical outcome.

Subjects, methods, and results

In January 1993 the Italian National AIDS Unit began a nationwide retrospective survey of symptomatic cases of acquired immunodeficiency without HIV infection. Cases were defined as having (*a*) one or more clinical conditions indicating severe immunosuppression; (*b*) depleted CD4 T lymphocytes (fewer than 300×10^6 cells/l or proportionately less than 20% of the lymphocyte count) at the time of clinical diagnosis; (*c*) no known cause of immunosuppression; and (*d*) negative results for HIV infection on enzyme linked immunosorbent assay (ELISA) and in at least one supplementary test. This case definition was circulated to all doctors who were considered most likely to have seen such patients—namely, immunologists and specialists in infectious diseases who had reported a high number of AIDS cases—in a letter asking them to compile standardised case reports.

Up to 30 June 1994, 13 case reports had been received from all over Italy. Two cases were immediately excluded because they did not meet diagnostic criteria; another case was later excluded because the patient developed sarcoidosis. The year of diagnosis of the 10 confirmed cases is reported in the table. The mean age was 47·3 years (range: 38-59); seven of the 10 cases were reported among men.

Only one patient (case 1) reported risk factors for HIV infection; another patient (case 6) came from Ethiopia and has been reported on previously. None of the patients reported injecting drug misuse, which is the most common risk factor for HIV infection in Italy. Eight patients had a regular sexual partner; four of the partners tested negative for HIV-1 and HIV-2 antibodies (the other four partners were not tested). None of the members of the patients' extended families had serious infections or problems with their immune system.

Characteristics of and outcome in Italian patients with acquired immunodeficiency without HIV infection

Case No	Sex, age (years)	Opportunistic disease	Lymphocyte count $\times 10^6$/l	CD4 count $\times 10^6$/l (%)*	CD8 count $\times 10^6$/l (%)*	Year of diagnosis	Outcome† (last CD4 count ($\times 10^6$/l))
1‡	M, 38	Kaposi's sarcoma	1130	280 (24·8)	740 (65·5)	1989	Alive (280)
2	F, 40	Herpes simplex virus infection, condylomas	864	224 (25·9)	346 (40·0)	1989	Alive (333)
3	M, 47	Oesophageal candidiasis, salmonellosis	1451	270 (18·6)	522 (36·0)	1990	Alive (322)
4	F, 46	Oesophageal candidiasis, pneumonia	966	10 (1·0)	179 (18·5)	1990	Dead
5	M, 48	Herpes simplex virus infection, oesophageal candidiasis, lymphoma, shingles	1620	162 (10·0)	470 (29·0)	1992	Dead
6	M, 53	Pulmonary tuberculosis, oral candidiasis	981	206 (21·0)	186 (19·0)	1993	Alive (NAc)
7	M, 53	Neurotoxoplasmosis, disseminated cytomegalovirus infection, lymphoma, Kaposi's sarcoma	1410	273 (19·4)	1188 (84·3)	1993	Dead
8	M, 39	Wasting syndrome, *Pneumocystis carinii* pneumonia, neurotoxoplasmosis, disseminated cytomegalovirus infection	2552	434 (17·0)	1378 (54·0)	1993	Dead
9	F, 50	Pulmonary and bone tuberculosis	436	167 (38·3)	167 (38·3)	1994	Alive (94)
10	M, 59	Cryptococcal meningitis	186	15 (8·1)	100 (53·8)	1994	Alive (42)

*Of lymphocyte count.
†By December 1994.
‡Risk factor for HIV infection (male to male sexual intercourse).
cMissing data—no follow up measure available.

Candidiasis was the most common opportunistic disease. All patients were negative for HIV-1 antibody and p24 antigen on ELISA. Western blotting for HIV-1 antibody and ELISA for HIV-2 antibody were performed in eight cases. In five cases supplementary techniques were used (culture (three cases), polymerase chain reaction (two)) and gave negative results. Nine patients had a CD4 count of less than 300×10^6 cells/l, the remaining patient (case 8) had a fairly high count, but it was proportionally less than 20% of the total lymphocyte count.

Four of the patients died during a median follow up time of 31·5 months (range: 6-66 months); the causes of death were opportunistic infections (in two), lymphoma, and vascular encephalopathy (stroke). The median survival time by Kaplan-Meier analysis was about 50 months. Of the survivors, only one showed a large decrease in the number of CD4 cells during follow up (from 167 to 94×10^6 cells/l); counts remained stable in the others.

Comment

Our survey found a few sporadic cases of acquired immunodeficiency without evidence of HIV infection. Only one patient reported typical risk factors for HIV infection, and there was no evidence of clusters or sexual transmission. The clinical characteristics of these patients were similar to those of people with HIV infection and AIDS, except that our patients had higher CD4+ counts at the time of diagnosis. Patients with acquired immunodeficiency without HIV infection survived longer than patients with AIDS, whose survival time is about 15 months in Italy.[5]

Our study confirms that acquired immunodeficiency without HIV infection is a sporadic phenomenon that does not seem to be associated with a single infectious agent. Though our patients tended to survive longer than patients with HIV infection and AIDS, survival times were highly variable. Follow up studies of larger populations are needed to define more clearly acquired immunodeficiency without HIV infection and its clinical variability.

The Italian Study Group on non-HIV AIDS also includes F Dammaco (Bari), S Casari (Brescia), R Finazzi (Milan), E Guerra (Rome), A Lazzarin (Milan), F Montella (Rome), E Pizzigallo (Chieti), and A Sinicco (Turin). We thank the Global Programme on AIDS of the World Health Organisation for giving us the case report form that we modified for data collection in this survey.

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1 Smith DK, Neal JJ, Holmberg SD. Unexplained opportunistic infections and CD4+ T-lymphocytopenia without HIV infection. *N Engl J Med* 1993;328: 373-9.
2 Ho DD, Cao Y, Zhu T, *et al.* Idiopathic CD4+ T-lymphocytopenia-immunodeficiency without evidence of HIV infection. *N Engl J Med* 1993;328:380-5.
3 McNulty A, Kaldor JM, McDonald AM, Baumgart K, Cooper DA. Acquired immunodeficiency without evidence of HIV infection: national retrospective survey. *BMJ* 1994;308:825-6.
4 Montella F, Viola P, Recchia O, Di Sora F, Rezza G. CD4+ T-lymphocytopenia and severe infections in an HIV-negative Ethiopian man. *AIDS* 1994;8:390-1.
5 Abeni DD, Perucci CA. Sopravvivenza dalla diagnosi di AIDS, Roma e Lazio 1982-1992. *Giornale Italiano dell'AIDS* 1993;4:16-25.

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ONE HUNDRED YEARS AGO

THE USE OF MEDICAL TITLES AFTER ERASURE FROM THE "REGISTER."

The prosecution by the General Medical Council of Mr. Thomas Richard Allinson has been successful. We cannot conceive how it could have been otherwise. The result of the trial should stimulate the General Medical Council not only to institute proceedings in similar cases, but to obtain increased powers from the Legislature for dealing with what is a flagrant evil.

Mr. Allinson held the title of L.R.C.P.Edin. His name was erased from the *Medical Register* by the General Medical Council, and he was deprived of his title by the College of Physicians of Edinburgh. He appealed from the decision of the General Medical Council both to the Queen's Bench Division and to the Court of Appeal, but failed on both occasions. Having done so, he continued to use the title, and for doing this he has been subjected by the magistrate to the penalty of £20 imposed by the 40th Section of the Medical Act of 1858, and to the costs of the prosecution.

That a person should be at liberty still to use a title of which he has been legally deprived would indeed be a startling anomaly, nor is it possible to find a case more fitly covered by the words of the 40th section, which enacts that: "Any person who shall wilfully and falsely pretend to be or take or use the name or title of a physician. . . . or any name, title addition or description implying that he is registered under this Act or that he is recognised by law as a physician etc. shall upon a summary conviction for any such offence pay a sum not exceeding £20." But will the profession remain satisfied without a further step being taken in the direction of medical reform?

(*BMJ* 1895;ii:93.)